CAREFOCUS HEALTH, INC.
APPLICATION FOR EMPLOYMENT

Federal and State laws prohibit discrimination in employment because of sex, race, creed, religion, national origin, age, handicap, marital status, status with regard to public assistance or veterans employment. We are an equal opportunity employer.

PERSONAL INFORMATION

Date _____

Name _____ Social Security # _____
Last First Middle

Other surnames that I have used: _____

Present Address _____
Street City State Zip

Permanent Address _____
Street City State Zip

Home Phone #: _____ Alternate Phone #: _____

How did you hear about this position? _____ Referred By: _____

Are you legally entitled to work in the United States? ☐ YES ☐ NO Are you at least 18 years of age? ☐ YES ☐ NO

In Case of Emergency Notify: _____
Name Phone # Relationship to you

U.S. Military or Naval Service _____ Rank _____ Present Membership in National Guard or Reserves? ☐ YES ☐ NO

EMPLOYMENT DESIRED

Position: ☐ RN ☐ LPN/LVN ☐ Homemaker ☐ Home Health Aide ☐ Staffing ☐ Clerical
☐ Personal Care Attendant ☐ Other _____

Have you passed Competency Testing? ☐ YES ☐ NO Do you have a Certificate? ☐ YES ☐ NO

Do you have a current Driver's License? ☐ YES ☐ NO Do you currently have a car? ☐ YES ☐ NO

Have you ever applied to this Company before? ☐ YES ☐ NO Where? _____ When? _____

PROFESSIONAL LICENSES, CERTIFICATION, AND REGISTRATIONS

Do you have any professional licenses, certifications and/or registrations? ☐ YES ☐ NO

License/Certificate/ Registration #:	Type	State Issued	Date Expires	Status (List Active, Inactive, Restricted, Conditional or Pending)

REFERENCES

Give below the names of three **work related** references.

NAME	ADDRESS	COMPANY/POSITION	PHONE

EDUCATION

	NAME AND LOCATION OF SCHOOL	YEARS ATTENDED	GRADUATED	DEGREE/CERTIFICATION
HIGH SCHOOL			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
COLLEGE			☐ Yes ☐ No	
ADDITIONAL TRAINING				

FORMER EMPLOYERS

List below your complete employment history for the last five years, starting with the most recent position first. Attach additional pages if necessary.

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER SUPERVISOR'S NAME	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO	May we contact? ☐ YES ☐ NO			
FROM				
TO				
FROM				
TO				
FROM				
TO				

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for rejection or dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated at any time, with or without cause, and with or without any prior notice.

Date_____ Signature_____

CAREFOCUS HEALTH, INC.

VOLUNTARY SELF-IDENTIFICATION INFORMATION

CAREFOCUS HEALTH, INC. is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to sex, race, color, national origin or ancestry, age, handicap, marital status, source of income, class, physical characteristics, sexual orientation or political beliefs.

As an employer, we comply with government regulations and affirmative action responsibilities. Solely to help us comply with government record keeping, reporting and other legal requirements, please complete this Voluntary Self-Identification Information form. This data is for analysis and affirmative action only and submission of this information is voluntary. This data will be kept in a confidential file separate from your Application for Employment.

Date_____

Position Applied For_____

Gender:

- ☐ Male
- ☐ Female
- ☐ Choose not to respond

Race/Ethnic Background:

- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black / African or African American
- ☐ Hispanic / Latino
- ☐ White / Caucasian
- ☐ Two or More Races
- ☐ Choose not to respond

Veteran Status:

- ☐ Vietnam era veteran
- ☐ Disabled veteran
- ☐ Other veteran
- ☐ Non-veteran
- ☐ Choose not to respond

Disability Status:*

- ☐ Disabled
- ☐ Not disabled
- ☐ Choose not to respond

* According to the American with Disabilities Act, the term "disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of that individual, a record of such an impairment, or being regarded as having such an impairment.

CAREFOCUS HEALTH, INC.

CONFIDENTIALITY OF CLIENT INFORMATION

AGENCY POLICY:

By accepting employment with **CAREFOCUS HEALTH, INC.**, you have obligated yourself to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. Do not pass on medical information to clients and visitors unless you have been instructed to do so by your supervisor. In addition, all information seen or heard regarding clients, directly or indirectly, is completely confidential and not to be discussed even with your family.

Your job as a **CAREFOCUS HEALTH, INC.** employee requires that you govern yourself by high ethical standards. Failure to recognize the importance of confidentially is not only a breach of this agency's policies, but can also involve an employee in legal proceedings. Information about clients or the agency is not to be given to media. This is essential for protection of both the client and the agency. Very strict laws regarding the release of information concerning clients bind agencies.

I have read and agree to abide by the above policy on confidentiality. I realize that violating this policy may result in termination of my employment.

_____

Employee Name (print)

_____ _____

Signature of Employee Date

CAREFOCUS HEALTH INC.

NetStudy 2.0

First Name: _____ Middle Name: _____

Last Name: _____

Permanent Address: _____

City: _____State: _____ Zip Code: _____County:_____

Mailing Address if different_____

Social Security Number: _____

Date of Birth: _____ Race: _____

Circle Sex: _____Female _____Male US Citizen: ___Yes____No

Eye Color:

Black__Blue__Brown__Gray__Green_Hazel_Maroon_Multicolor_Pink_Unknown

Hair: _____ Height: _____ Weight: _____

Place of Birth: _____

Phone Number: _____ Type: Mobile / Work / Home

Secondary Phone: _____ Type: Mobile / Work / Home

Email: _____

Prior Names & Aliases:

First Name: _____ Middle Name: _____ Last Name: _____

Minnesota New Hire Reporting Form

Effective July 1, 1996 Minnesota Statute 256.998 requires all Minnesota Employers, both public and private, to report all newly hired, rehired, or returning to work employees to the State of Minnesota within 20 days of hire or rehire date. Information about new hire reporting and online reporting is available on our web site: www.mn-newhire.com

Send completed forms to:
Minnesota New Hire Reporting Center
PO Box 64212
St. Paul, MN 55164-0212
Toll-free fax: (800) 692-4473

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C		1	2	3

EMPLOYER INFORMATION

Federal Employer ID Number (FEIN) *(Please use the same FEIN as the listed employee's quarterly wages will be reported under):*

Employer Name:

Employer Address *(Please indicate the address where the Income Withholding Orders should be sent).*

Employer City: Employer State: Zip Code (5 digit):

Employer Phone: Extension: Employer Fax:

Email:

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

Check this box if this is an Independent Contractor (1099) ☐

Employee First Name: Middle Initial:

Employee Last Name:

Employee Address:

Employee City: Employee State: Zip Code (5 digit):

Date of Hire (mm/dd/yyyy): Date of Birth (mm/dd/yyyy): (optional) Employee State of Hire

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

Questions? Call us at (651) 227-4661 or toll-free (800) 672-4473

Rev (04/12)